

**APPLICATION FOR APPROVAL UNDER THE OMNIBUS BUDGET
RECONCILIATION ACT FOR NURSE AIDE TRAINING PROGRAM**

RETURN FIVE (5) COPIES TO:

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF HEALTH CARE QUALITY

**ATTENTION: ALEEN WILKER, APRN, CRNA, RN
CAN COMPLIANCE NURSE
263 CHAPMAN ROAD, SUITE 200, CAMBRIDGE BUILDING
NEWARK, DELAWARE 19702**

Notice of Non-Discriminatory Policy

The State of Delaware does not discriminate in program funding of services to participants on basis of race, color, religion, sex, national origin, age handicap, or political affiliation or belief.

Applicant Name: _____

Address: _____

Training Sites _____	Types of Training _____
_____	_____
_____	_____
_____	_____

Contact Person _____ Tel.: _____

Initial Start Date Requested _____

*Please allow at least 90 days for processing.

Was pre-approval obtained by the Department of Education? Yes No N/A

To Be Completed by Division:

Approval Date: _____ Program ID #: _____ PIN #: _____

I. BRIEF DESCRIPTION OF PROPOSED PROGRAM ACTIVITY TO BE OFFERED:

- A. Description of course with goals and objectives.
- B. Name of textbook with edition noted.
** Should be older than five (5) years.*
- C. Breakdown of program hours for theory and clinical.
- D. Instructor to student ratios for both clinical and classroom.
- E. Proposed funding for the course.

II. TRAINING & CURRICULUM DESIGN:

- A. Attach a training outline of your curriculum for your entire course including the amount of time (weeks, hours) devoted to both academic and/or skill development and a brief description of your teaching and evaluation methods. The curriculum content for the nurse aide training program must include material that will provide a basic level of both knowledge and demonstratable skills for each individual completing the program. The program must be a minimum of 150 hours divided equally between clinical and classroom instruction. Additional hours may be in either of these areas or both.
(See Appendix, page 11.)
- B. Include behaviorally stated objectives for each unit of instruction. Each objective must state performance criteria which are measurable, and which serve as the basis for competency evaluations. The unit objective must be reviewed with the trainee at the beginning of each unit so that each trainee will know what is expected.
(See Appendix, page 12.)
- C. Provide a classroom and clinical schedule showing days and hours of course, subjects and required reading. Please indicate when tests and quizzes will be administered, lunch and break times are given and when students will receive CPR certification. Please note that lunch and break times are subtracted from total program hours. Please maintain a classroom and clinical schedule for each class offered once approved.
(See Appendix, page 10.)
- D. Attach a list of Equipment and Supplies to be used during the training as required in the State of Delaware CNA Training Regulations (16, Del C. §3220).

- E. Submit a sample lesson plan for one unit of instruction that includes behavioral objectives, content and learning activities, including evaluation.

III. PROGRAM LOCATION

- A. Complete a Clinical Facility Request Form for each site used by the program providers.
(See Appendix, page 6.)
- B. Please attach a copy of an affiliation agreement(s)/contract for clinical instructions/training if you are not a facility-based program. Please specify the terms of the agreement and the responsibilities of both parties.
- C. Attach clinical objectives and rationale for the selection of the facility.

IV. ENROLLMENT

- A. Indicate how many students can be handled during anyone training period and how often you plan to offer the training in any given year.

V. STAFFING

- A. Submit an organizational chart showing all program positions (administrative, instructional and support) and their relationship to the overall administrative structure of the agency including the names of staff under each indicated category.
- B. Provide job descriptions for the Primary Instructor (Program Coordinator and other instrumental staff.)
- C. Complete Qualification Sheets for all Nursing Instructors and other instructional staff/guest speakers.
(See Appendix, pages 8 & 9.)

VI. EVALUATION AND MONITORING

Under this heading, describe how you will evaluate and monitor our training program.

- A. Describe what will be done to determine how your program goals and objectives are being met.

APPENDIX

CLINICAL FACILITY REQUEST FORM

For an initial request to utilize a (licensed) long-term care facility as a clinical site, the following information is needed to determine the adequacy of the facility before approval can be given. You must also attach a copy of your contract with the clinical facility. Please contact Aleen.wilker@delaware.gov for a current list of restricted facilities.

Name of Provider Initiating Request _____
 Name of Facility to be used _____
 Address _____ Telephone Number _____
 Facility Administrator _____ State License Date _____
 Director of Nursing _____ Total Bed Capacity _____
 Daily Patient Average or No. of Patients Served _____

Clinical Area(s) to be used:

<u>TYPE</u>	<u>NO. OF UNIT(S)</u>	<u>AVERAGE CENSUS PER UNIT</u>
Long Term Care	_____	_____
	_____	_____
Home Care	_____	_____
Acute Care	_____	_____
Psychiatric Care	_____	_____
Other	_____	_____

Describe size, location and availability of offices and equipment available for the nursing instructors:

Provisions for faculty and students: (Describe size, location and availability)

- a. Library _____
- b. Conference Rooms _____
- c. Classrooms _____
- d. Locker Rooms and/or dressing rooms for
 faculty/students _____
- e. Instructional aids and equipment _____

Please forward completed forms with required documents to: Aleen.wilker@delaware.gov

NURSING ASSISTANT PRIMARY DIDACTIC INSTRUCTOR QUALIFICATIONS

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School/Program Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Full Time: _____ Part Time: _____

Nursing License Number: _____ *ATTACH CURRENT COPY

BLS Certification: _____ *ATTCH CURRENT COPY

PPD Documentation annually if clinical Faculty: _____ *ATTACH CURRENT COPY

GOVERNMENT ISSUED PHOTO ID: * ATTACH CURRENT COPY

ATTACH RESUME WITH EMPLOYMENT HISTORY FOR PAST FIVE YEARS: INCLUDE EMPLOYER NAME WITH ADDRESS AND TELEPHONE, DATES EMPLOYED (MONTH/DAY/YEAR), POSITION

***APPLICANT MUST HAVE A MINIMUM OF TWO YEARS REGISTERED NURSE EXPERIENCE. AT LEAST ONE OF THOSE YEARS OF NURSE EMPLOYMENT MUST BE IN THE PROVISION OF FEDERAL SKILLED NURSING HOME FACILITY SERVICES OR SUPERVISION AND/OR TEACHING OF STUDENTS, IN A DELAWARE LICENSED NURSING FACILITY.**

***APPLICANT MUST HAVE A MINIMUM OF ONE YEAR TEACHING EXPERIENCE OF ADULTS IN A CLASS OF SIX OR MORE STUDENTS OR STAFF DEVELOPMENT OR DHSS-DHCQ APPROVED 12 HOUR, "TRAIN THE TRAINER" CERTIFICATE.**

CERTIFICATE

IF APPLICANT HAS ATTENDED "TRAIN THE TRAINER" CLASS PROVIDE DATE, SPONSOR, AND ATTACH CERTIFICATE OF COMPLETION

I certify that the above information is correct. I give permission to the Division of Health Care Quality to contact my current/past employers to verify the accuracy of this information.

Signature and Title: _____ Date: _____

Please forward completed forms with required documents to: Aleen.wilker@delaware.gov

NURSING ASSISTANT SECONDARY CLINICAL INSTRUCTOR QUALIFICATIONS

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

School/Program Name: _____ NATCEP# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Full Time: _____ Part Time: _____

Nursing License Number: _____ *ATTACH CURRENT COPY

BLS Certification: _____ *ATTCH CURRENT COPY

PPD Documentation annually if clinical Faculty: _____ *ATTACH CURRENT COPY

GOVERNMENT ISSUED PHOTO ID: * ATTACH CURRENT COPY

ATTACH RESUME WITH EMPLOYMENT HISTORY FOR PAST FIVE YEARS: INCLUDE EMPLOYER NAME WITH ADDRESS AND TELEPHONE, DATES EMPLOYED (MONTH/DAY/YEAR), POSITION

***APPLICANT MUST HAVE A MINIMUM OF TWO YEARS REGISTERED NURSE EXPERIENCE OR THREE YEARS OF LICENSED PRACTICAL NURSE EXPERIENCE.**

***APPLICANT MUST HAVE A MINIMUM OF ONE YEAR TEACHING EXPERIENCE OF ADULTS IN A CLASS OF SIX OR MORE STUDENTS OR STAFF DEVELOPMENT OR DHSS-DHCQ APPROVED 12 HOURS, "TRAIN THE TRAINER" CERTIFICATE.**

IF APPLICANT HAS ATTENDED "TRAIN THE TRAINER" CLASS PROVIDE DATE, SPONSOR, AND ATTACH CERTIFICATE OF COMPLETION.

I certify that the above information is correct. I give permission to the Division of Health Care Quality to contact my current/past employers to verify the accuracy of this information.

Signature and Title: _____ Date: _____

Nursing Assistant Course (Sample Only) Class and Clinical Schedule

Textbook required readings are listed on the right side of each lecture/clinical topic. All readings are from Name of Textbook. Students are encouraged to perform required reading prior to attending class in order to facilitate the material presented.

DATE	TIME	SUBJECT	REQUIRED READING
Monday, June 4, 2007	0830-1030	Orientation to the Nursing Assistant Course	
	1030-1130	Unit I: Introduction to the Nursing Assistant Course	
	1130-1230	The Health Care System Lunch	Chapter 1, p. 1-12
	1230-1400	Role of the Nursing Assistant	Chapter 2, p. 13-31 Chapter 4, p. 62-74
Tuesday June 5, 2007	0830-1000	Patients, Residents, and Clients	
	1000-1130	Working with People	
	1130-1230	Lunch	
	1230-1330	Understanding Basic Human Needs	
	1330-1430	Home Health Care	Chapter 11, p. 227-247
	1430-1600	Unit II: Physical Needs of the Patient Food and Nutrition	Chapter 21, p. 443-455
Wednesday June 6, 2007	0830-0930	Feeding Special Needs Patients-Guest Speaker	
	0930-1130	Observing Body Functions	
	1130-1230	Lunch	Chapter 19, p. 382-408
	1230-1530	Vital Signs Practice Lab-Mandatory	
Thursday June 7, 2007	0830-0930	Exam: Unit I	
	0930-1230	Body Systems	
	1230-1330	Lunch	
	1330-1500	Vital Signs Practice Lab-Mandatory	Chapters 14, 16, 17, 18, 20

EXAMPLE OF CONTENT	TIME FRAME	TEACHING METHOD	EVALUATION METHOD
<p>Unit I Introduction to the Nursing Assistant Course</p> <p>A. The Health Care System</p> <ol style="list-style-type: none"> 1. The Health Care Environment <ol style="list-style-type: none"> a. Purpose of Health care delivery system b. Diagnosis-related groups c. Manage care 2. Health Care Delivery sites <ol style="list-style-type: none"> a. Services available b. Organizational structure <ol style="list-style-type: none"> 1) Hospital 2) Nursing Service 3) Organization of the Health Care Team <p>B. Role of the Nursing Assistant</p> <ol style="list-style-type: none"> 1. Job Description 2. Roles and Responsibilities 3. Personal Qualities 4. Managing Time and Resources 5. Ethical Behavior <ol style="list-style-type: none"> A. Confidentiality B. Accuracy C. Dependability 6. Legal Aspects of patient Care <ol style="list-style-type: none"> a. The Resident's Bill of Rights b. Standards of Care c. Consent d. Abandonment 7. Incidents 	<p>7.5 hours</p> <p>1 hour</p> <p>1.5 hours</p>	<p>Lecture/Discussion/Handouts</p> <p>Organization Charts</p> <p>Lecture/Discussion Job Description for a nursing assistant</p> <p>Video-"Well Shut My Mouth"</p>	<p>Quiz # 1</p>

NURSING ASSISTANT TRAINING COURSE

UNIT 1: INTRODUCTION TO THE NURSING ASSISTANT COURSE

EXAMPLE OF UNIT OBJECTIVES:

At the completion of this unit, the student will:

1. Describe how agencies make services available to patients and families.
2. Explain the purposes and goals of the nursing assistant services.
3. Discuss the roles of the nursing assistant in the hospital, long-term care facility, and in the home.
4. Explain why nursing assistants do NOT administer medications.
5. Identify ways to manage time and conserve resources.
6. Identify resources within the family and the community.
7. Identify ways in which people communicate with each other.
8. Describe the difference between verbal and non-verbal communication.
9. Describe methods for achieving therapeutic communication.
10. Describes basic human needs which nursing assistant services help to meet.
11. Identify ways in which individuals and families may differ.
12. Describe how people may feel and behave when needs are unmet.

3.10 MINIMUM EQUIPMENT REQUIRED:

- 3.10.1 _____ Audio/Visual
- 3.10.2 _____ Teaching Mannequin, Adult, for catheter and perineal care
- 3.10.3 _____ Hospital Bed
- 3.10.4 _____ Bedpan/Urinal
- 3.10.5 _____ Bedside commode
- 3.10.6 _____ Wheelchair _____
- 3.10.7 _____ Scale
- 3.10.8 _____ Overbed Table
- 3.10.9 _____ Sphygmomanometer
- 3.10.10 _____ Stethoscope
- 3.10.11 _____ Resident/patient gowns, linens and at least four (4) pillows
- 3.10.12 _____ Thermometers
- 3.10.13 _____ Crutches
- 3.10.14 _____ Canes (Variety)
- 3.10.15 _____ Walker
- 3.10.16 _____ Gait Belt
- 3.10.17 _____ Miscellaneous supplies
 - Bandages _____
 - Compresses _____
 - Heating Pad _____
 - Hearing Aid _____
 - Dentures _____
 - Toothbrushes _____
 - Razors _____
 - Bath/Emesis Basins _____
 - Compression Stockings _____
- 3.10.18 _____ Foley Catheter Drainage Bag
- 3.10.19 _____ Mechanical lift
- 3.10.20 _____ Adaptive eating utensils/equipment

CNA CLINICAL SKILLS PROFICIENCY CHECKLIST

32. <i>Assist resident with meal set-up</i>			
33. * Dress & undress resident with affected arm			
34. Put elastic stockings on resident			
35. * Perform passive range of motion (shoulder)			
36. * Perform passive range of motion (elbow/wrist/hand)			
37. * Perform passive range of motion (hip/knee/ankle/foot)			
38. * Take and record pulse			
39. * Count and record respirations			
40. * Take and record Blood Pressure			
41. * Take and record temperature			
42. * Measure and record height			
43. * Measure and record weight			
44. Provide cold application safely			
45. Provide heat application safely			
46. Apply heel/elbow protectors			
47. * Provide appropriate care for sensory impairment			
48. * Respectful delivery of care			
49. * HIPAA/confidentiality maintained			
50. Uniform/identification appropriate			
51. Non-verbal communication appropriate			
52. * Recognizes dementia/anxiety/resident fears			

Number of clinical hours	
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Faculty Signature		Date	
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Student Signature		Date	
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* – Completion required before clinical rotation

Bold – Included in Prometric testing

Italics – Included in or supportive of testing skill

Instructor Reminder

Document clinical attendance dates and number of hours to attendance tracking sheet.

CNA CLINICAL SKILLS PROFICIENCY CHECKLIST

NATCEP #		Clinical Site	
Student Name		Instructor Name	

Clinical Skills	Completion Date	Student Initials	Faculty Initials
1. * Hand washing/ Hand hygiene			
2. * Apply and remove a full set of PPE			
3. Perform isolation precautions			
4. * <i>Ensure resident rights-knock/identify/explain/privacy</i>			
5. * <i>Ensure resident room safety</i>			
6. * Make occupied bed			
7. * Turn & position resident on side or back			
8. * Transfer resident from bed to wheelchair w/ transfer belt			
9. * Assist with ambulation with gait belt			
10. * Assist ambulation using walker			
11. * Assist a resident to use a cane			
12. Use a mechanical lift			
13. * <i>Measure water temperature</i>			
14. * Provide Hand and nail care			
15. * Provide foot care			
16. * Provide mouth care – person with teeth			
17. * Oral care & Clean and store dentures			
18. * Shave a beard/mustache			
19. * Groom/shampoo hair			
20. * Provide complete bed bath			
21. * Provide modified bed bath (partial)			
22. <i>Provide backrub/PM care</i>			
23. * Provide Perineal care for incontinent resident			
24. * Provide Foley catheter care			
25. Apply condom catheter			
26. * Measure and record fluid output (drainage bag)			
27. * Assist with bedpan			
28. * Assist with urinal			
29. * Feed resident who cannot feed self			
30. * <i>Measure & record meal intake</i>			
31. <i>Measure and record fluid intake</i>			